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ABSTRACT

The question of whether or not depressive personality disorder is a distinct disorder separate from mood disorders or other personality disorders has historically been debated by researchers and theorists and continues to be a topic of disagreement. Empirical studies reveal that only a modest relationship may exist between depressive personality disorder, mood disorders, and other personality disorders. This suggests that depressive personality disorder may be distinct from mood disorders and other personality disorders. Further investigations should focus on clearer discrimination between depressive personality disorder and other personality disorders. Chapters in this review of the literature are: (1) Introduction; (2) Historical Background of Depressive Personality, (3) Characterological Depressions as a Subtype of Dysthymia, (4) Comorbidity of Dysthymia with Axis II Disorders, (5) Depressive Personality as a Distinct Personality Disorder, and (7) Conclusions. An unpublished instrument, "Diagnostic Interview for Depressive Personality (DID)" is included as an appendix. Contains 37 references. (Author/JBJ)

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DEPRESSIVE PERSONALITY DISORDER

A REVIEW OF THE LITERATURE

by

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DEPRESSIVE PERSONALITY DISORDER

A REVIEW OF THE LITERATURE

A Doctoral Research Paper

Presented to

the Faculty of the Rosemead School of Psychology

Biola University

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Psychology

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by

Beverley A. Sale

May, 1996

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The question of whether or not depressive personality disorder is a distinct disorder separate from mood disorders or other personality disorders has historically been debated by researchers and theorists and continues to be a topic of disagreement. Empirical studies reveal that only a modest relationship may exist between depressive personality disorder, mood disorders, and other personality disorders. This suggests that depressive personality disorder may be distinct from mood disorders and other personality disorders. Further investigations should focus on clearer discrimination between depressive personality disorder and other personality disorders.

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DEPRESSIVE PERSONALITY DISORDER

A REVIEW OF THE LITERATURE

Introduction

Depressive Personality has a rich theoretical and clinical history but until recently the disorder has been overlooked in the official nomenclatures and in the empirical research literature. Recently, there has been a renewal of interest in the concept of depressive personality disorder as a separate and distinct personality disorder (Phillips, Gunderson, Hirschfeld, & Smith, 1990). Current empirical literature has sought to define depressive personality as distinct from mood disorders and other personality disorders, legitimizing its inclusion in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV; American Psychiatric Association, 1994) as an Axis II personality disorder. This review summarizes the history of the concept and classification of depressive personality and examines current empirical literature supporting the validity of the proposed Depressive Personality Disorder.

Historical Background of Depressive Personality

History of the Concept of the Depressive Personality

According to Hirschfeld and Holzer III (1994), Kraepelin (1921) was the first to describe the depressive personality. He characterized a "depressive temperament" as consisting of persistent gloominess, joylessness, anxiety, and a predominantly depressed, despondent, and despairing mood. Patients with this temperament were also described as serious, burdened, guilt-ridden, self-reproaching, self-denying, and lacking in self-confidence. Kraepelin believed that the depressive temperament was inherited, recognizable by adolescence or early adulthood, and persistent throughout a patient's lifetime. Moreover, Kraepelin considered the depressive temperament to be a "fundamental state" which could persist unchanged, fluctuate, or sometimes develop into actual melancholia or "become the point of departure" for more florid depressive episodes (Hirschfeld & Holzer III, 1994).

Schneider (1958) developed the modern descriptive approach to personality disorders in the late 1950's and described depressive personality disorder by the following symptomatic criteria: (a) gloomy, pessimistic, serious, and incapable of enjoyment or relaxation; (b) quiet; (c) skeptical; (d) worrying; (e) duty-bound; and (f) self-doubting. Schneider believed that depressive personality disorder was more related to normal personality traits and

other personality disorders than to mood disorders (Hirschfeld & Holzer III, 1994).

According to Phillips et al. (1993), Otto Kernberg of the psychoanalytic tradition described a "depressive character" which, like Kraepelin's depressive temperament, was characterized by gloominess and pessimism (Kernberg, 1984). In addition, Kernberg included excessive self-demand, extreme interpersonal neediness, and fear of rejection in his conceptualization of the depressive character.

History of the Classification of Depressive Personality

The early versions of the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 1952 and 1968) bore the stamp of psychoanalytic thought. Although DSM-I (1952) and DSM-II (1968) had no clear equivalent of the depressive personality, both classified nonpsychotic depressions under the neuroses and personality disorders. In such sections, analytic concepts such as unconscious conflict and defense mechanisms had a central etiologic role. DSM-I (1952) listed depressive reaction under the psychoneuroses and cyclothymic personality under the personality disorders.

DSM-II (1968) replaced depressive reaction with depressive neurosis. In addition, DSM-II (1968) contained two new related diagnoses: neurasthenic neurosis, characterized by chronic weakness and easy fatigability, and

asthenic personality disorder, also defined by easy fatigability as well as by low energy level, lack of enthusiasm, incapacity for enjoyment, and oversensitivity to physical and emotional stress. According to Phillips, Gunderson, Hirschfeld, & Smith (1990), DSM-II's (1968) neurasthenic neurosis appeared most closely related to the depressive personality as it differed from the depressive neurosis in the moderateness of the depression and in the chronicity of its course. However, since depression was not clearly a defining characteristic of neurasthenic neuroses, and neither neurasthenic neuroses nor asthenic personality were much used, DSM-II's (1968) depressive neuroses appeared to have subsumed all forms of milder depression, including the equivalent of the depressive personality.

Dissatisfaction with the category of neuroses led to its deletion in the DSM-III (1980), and a new disorder, dysthymia, came into existence to characterize chronic depressions (Hirschfeld & Holzer III, 1994). Dysthymia required a two-year history of symptoms characteristic of the depressive syndrome but of insufficient severity to meet the criteria for a major depressive episode. According to Phillips, Gunderson, Hirschfeld, & Smith (1990), the change from depressive neurosis to Axis I affective disorder rather than Axis II personality disorder was one of DSM-III's (1980) most controversial modifications, provoking sharp protest from the psychoanalytic community.

The most widely voiced criticisms of the dysthymic disorder diagnosis have been identical to those lodged against the depressive neurosis diagnosis, that is, its overinclusiveness and extreme heterogeneity. In an effort to address such problems, DSM-III-R (1987) made several changes in the definition of dysthymia. Course modifiers were added, including primary and secondary dysthymia and early and late-onset, with late-onset occurring after the age of 21 years. While these modifiers helped to more precisely classify mild, chronic depression, they failed to provide a place for patients who have a depressive character structure but whose symptoms are less severe and persistent than those required for a dysthymic disorder diagnosis (Kernberg, 1984). Kocsis and Frances (1987) have argued that the framers of the DSM-III (1980) "seem to provide premature closure on the question of whether dysthymia represents a spectrum of affective disorders or a spectrum of character pathology, or, more likely, whether dysthymic disorder is a heterogeneous category including both sorts of patients" (p. 1539).

In response to the criticisms lodged against the DSM-III (1980) and DSM-III-R (1987) diagnostic category of dysthymia, many authors have suggested that depressive personality be teased out from dysthymic disorder and placed on Axis II (Goldstein et al., 1988). A subgroup of the DSM-IV Work Group on Personality Disorders has developed a

proposal for depressive personality disorder for DSM-IV (1994) (Hirschfeld & Holzer III, 1994), and the diagnosis currently appears in Appendix B of DSM-IV (1994), "Criteria Sets and Axes Provided for Further Study."

Characterological Depressions as a Subtype of Dysthymia

Akiskal is one of the earliest and most prolific researchers who empirically studied characterological depression and proposed that a depressive personality disorder be teased apart from dysthymia and put on Axis II (Phillips, Gunderson, Hirschfeld, & Smith, 1990). Troubled that all chronic and characterological depressions had been subsumed under "dysthymic disorder" in DSM-III (1980), Akiskal, Rosenthal, Haykal, Lemmi, Rosenthal, and Scott-Strauss (1980) sought to empirically discriminate between chronic and characterological depressions. They asserted that chronic depressions may begin at any age but occur most frequently in the elderly. In contrast, according to Akiskal et al. (1980), "characterological" implied developmental origin with dysphoric manifestations evident at least by early adulthood. They further asserted that "Inherent in the concept of characterological depression is an intertwining of depression and character such that depression becomes an integral and prominent part of the personality" (Akiskal et al., 1980). Furthermore, individuals suffering from characterological depression were

considered to have a "depressive life style," and to be poor responders to somatic treatment and psychotherapy. Figure 1 depicts the diagnostic schema for Axis I mood disorders set forth in DSM-IV (1994). It is provided to facilitate an understanding of how findings from each study fit into the larger diagnostic picture.

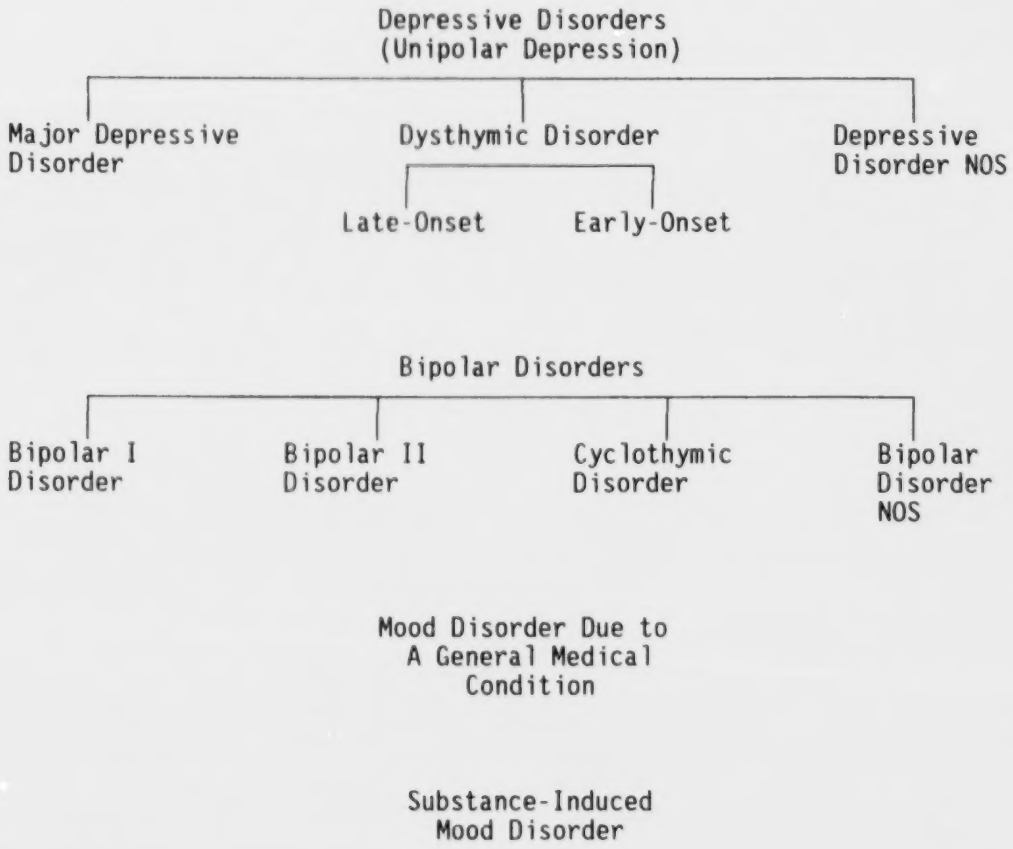

Figure 1. Axis I mood disorders as described in the Diagnostic and Statistical Manual of Mental Disorders (4th ed.), by American Psychiatric Association, 1994, Washington, DC: Author.

In their 1980 report, Akiskal et al. presented a study of characterological depressions proper along with evidence supporting the division of characterological depressions into distinct subtypes. Characterological depressions were subtyped on the basis of demographic, phenomenological, sleep EEG, treatment response, and follow-up variables. Their central hypothesis was that some characterological depressions represented a subsyndromic and lifelong version of primary affective illness, but others constituted a heterogeneous group of nonaffective personality disorders.

The population in the Akiskal et al. (1980) study was comprised of 50 patients who had suffered from "pure" characterological depressions for five or more years. To obtain this group, Akiskal et al. (1980) screened all chronically depressed patients over a four-year period who had been referred to a mood clinic program, a sleep disorder center, and a university-based outpatient private practice. The following criteria were used to select the characterological group: (a) onset before age 25, (b) duration of at least five years, (c) predominance of depressive symptoms that represented the patients' habitual trait, (d) the condition did not represent the residuum of a well-defined depressive episode that required psychiatric hospitalization, (e) absence of a diagnosable nonaffective psychiatric disorder, and (f) the condition was not an understandable reaction to a disabling lifelong medical

illness.

Social outcome was considered unfavorable when the patient demonstrated one of the following: (a) lost job and continued unemployment, (b) lack of performance of household duties or loss of custody of children by housewife, (c) dropping out of school and remaining out of school, (d) qualification for social security income as a result of mental disability, or (e) withdrawal from interpersonal relationships to the point of isolation. Sleep EEG recordings were obtained from the sleep disorder center to assess rapid eye movement (REM) latency for about one third of the patients. (REM latency is the time elapsed from sleep onset to the beginning of the first REM period.)

Patients were treated with supportive and crisis-oriented psychotherapy and family, social, and vocational counseling when appropriate. "Refractory" patients were usually treated with chemotherapy. Behavioral or cognitive therapy was added when the combination of standard care and chemotherapy was not effective. Patients were followed up for an average of 22 months, with a range of one to four years.

Patients whose symptoms remained unchanged after an average of six months of treatment were labeled "nonresponsive," and those with symptomatic improvement were considered "responsive." By those criteria, 20 of 65 patients with characterological depression were responsive,

leaving 45 patients who were nonresponsive. All responders, but only 30 of the 45 nonresponders, were included in the study. (Subjects excluded from the nonresponder group were clearly treatment-nonresponsive and demographically identical to the remaining nonresponders; however, their records did not contain details on all the variables reported.) Responders and nonresponders were compared with a third group of 40 control patients with unipolar depression chosen from the same clinical settings. The mean age of the unipolar group was 47 years, as compared with 29.2 and 31 years for the responder and nonresponder groups, respectively.

Although both characterological groups reported insidious onset of depression before the age of 25 years, nonresponders were more apt to complain of being unhappy for as long as they remembered. By contrast, patients in the unipolar control group reported onset of symptoms after the age of 25 as an outgrowth of a definable affective episode. Histories of school failure, social withdrawal, suicide attempts, and substance abuse were reported by both characterological groups; however, adolescent psychiatric histories of the unipolar control group were unremarkable. While the unipolar and nonresponder groups were predominantly female, the responder group exhibited an even sex ratio.

While hypersomnia was a more common complaint among

responders, insomnia was more characteristic of the nonresponders and the unipolar control group. The two characterological groups exhibited few vegetative signs; however, psychological symptomology such as dysphoric mood, feelings of inadequacy, pessimistic outlook, lethargy, and social withdrawal were prominent features. Clinicians described the majority of patients in the nonresponder group as exhibiting "unstable" characterological features such as passive-dependent, histrionic, antisocial, or borderline traits; by contrast, responders and control patients were predominantly described as displaying "stable" personality attributes such as compulsivity and narcissism. The mean REM latencies of responders and unipolar controls were similar but considerably shorter than those of nonresponders which were similar to nondepressed controls. A highly significant proportion (60%) of nonresponders abused alcohol and sedative-hypnotic drugs as compared with the other two groups. Thirty percent of nonresponders generally had unfavorable social outcome. The other two groups had good social outcome.

Based on the differential experiences of the responder and nonresponder characterological groups, Akiskal et al. (1980) concluded that characterological depressions were, indeed, heterogeneous. Akiskal et al. (1980) asserted that responders shared many of the characteristics of primary affective illness. Therefore, they designated the

responders as having "subaffective dysthymia." On the other hand, patients in the nonresponsive characterological group were designated as having "character spectrum disorder," due to their display of many variables associated with personality disorders such as impulsivity, immature and manipulative behavior, interpersonal instability, and high incidence of substance abuse.

Akiskal et al. (1980) suggested that the chronic dysphoria in the character spectrum disorders group (nonresponders) may have been related to undesirable home conditions provided by alcoholic fathers and their spouses. Moreover, they suggested that serious personality disturbances may have antedated an episode of depression. In other words, character spectrum disorders may have consisted of various personality disorders with secondary dysphoria.

One of the strengths of the Akiskal et al. (1980) study was the investigation of various domains of functioning of chronically depressed patients such as demographical, phenomenological, social, sleep EEG, as well as treatment response. The conclusions of Akiskal et al. (1980) were based on defining characteristics of subaffective dysthymia, characterological depressions, and unipolar depression on the basis of a convergence of findings. Another important feature of this study was the treatment component with a follow-up period. Patients were deemed nonresponsive to

treatment if symptom improvement had not occurred after a six-month period. Treatment modalities included supportive, crisis-oriented, family, social, vocational, chemotherapy, behavioral, and cognitive therapy. Only 20 out of 65 patients with characterological depression responded to such treatment, suggesting that longer term treatment may be necessary for most sufferers of chronic depression.

To provide a clinical framework for understanding chronic depressions, Akiskal, King, Rosenthal, Robinson, and Scott-Strauss (1981) performed a subsequent study which focused on the late-onset chronic depressions, comparing them with the characterologic group and the episodic unipolar controls. The study group comprised of 137 cases of chronic depression of at least two years' chronicity whose condition fell short of meeting the criteria for major depression. Chronic depressive subjects were referred to Akiskal et al.'s (1981) program from psychiatric, community, and medical care sources.

Phenomenologic data, life events, personality functioning, childhood object loss, and family history were assessed by way of a semistructured mood clinic questionnaire. Phenomenologic data were based on longitudinal observation and patients' report of psychopathologic experiences. Schneider's depressive typology (1958) was applied in a checklist and incorporated into the mood clinic questionnaire. At least five of the

following items were required for a diagnosis: (a) quiet, passive, and nonassertive; (b) gloomy, pessimistic, and incapable of fun; (c) self-critical, self-reproaching, and self-derogatory; (d) skeptical, hypercritical, and complaining; (e) conscientious and self-disciplining; (f) brooding and given to worry; and (g) preoccupied with inadequacy, failure, and negative events to the point of morbid enjoyment of such traits.

Developmental object loss was assessed by the following criteria: (a) subject born out of wedlock, and parents did not subsequently marry or live together; (b) one or both parents lost by death prior to age 15 years; (c) parents separated or divorced before subject turned 15; (d) subject adopted or lived in foster homes or orphanages. Family history was obtained for first degree biological relatives. Assortative mating (cases where both parents suffered from psychiatric disorders) was particularly noted.

The study of Akiskal et al. (1981) was carried out in the affective disorders program described by Akiskal et al. (1980). The chronic depressives were also discriminated in the same manner as that of the previous study, that is, chronic depressions with early-onset (less than 25 years of age) were separated from those with late-onset (25 years of age or greater). There were 50 subjects in the early-onset group whose designation was "characterologic depression." The characterologic depression group was further divided

into "characterologic proper" (30 patients) and "dysthymia proper" (20 patients). The characterologic depression subgroups corresponded to the Akiskal et al. (1980) designations of character spectrum disorder and subaffective dysthymia, respectively. There were 38 patients in the late-onset group whose designation was "chronic primary unipolar depression." The two groups were further distinguished from a third group of 49 subjects of chronic secondary depressions that arose in the context of pre-existing nonaffective disorders.

Based on the methodology used by Akiskal et al. (1980), 20 of the 50 characterologic depressives in the 1981 study were considered responders, and the remaining 30 subjects were nonresponders. The two groups of characterologic depressives were compared with the remaining chronic depressives comprising the chronic secondary and chronic primary groups. A control group of 40 episodic primary unipolar depressives was also chosen for comparison.

Patients were observed for six months to six years, with a mean follow-up of about three years. Most patients in the program received a combination of tricyclic antidepressants and practical psychotherapy. Sixty-two of the total sample of 137 patients had significant symptomatic and social improvement. Positive treatment responders were distributed as follows: 20 in the characterologic depressive group, 17 in the secondary group, and 25 in the

chronic unipolar group. Severe character pathology was most prominent in the 30 nonresponders among the characterologic depressives.

In the 1981 study, Akiskal et al., used the Schneiderian typology as a basis for comparison of the groups with respect to personality features. Schneiderian features were highly characteristic of the subaffective dysthymic group (75%), less characteristic of the primary chronic group (44%), and unipolar control group (28%), and uncharacteristic of the character spectrum and chronic secondary groups (10% in each). Five group chi-square comparisons showed a highly significant difference, particularly between the subaffective dysthymic group and the others.

The character spectrum group reported the lowest rate of family history of depression. In contrast, subaffective dysthymic patients presented the strongest familial background for total affective illness. Chronic unipolar patients were the next highest. When compared with the subaffective dysthymic, chronic unipolar, and episodic unipolar groups, the character spectrum group had significantly greater rates of familial alcoholism, familial assortative mating, and developmental object loss.

The Akiskal et al. (1981) investigation both extended and substantiated the Akiskal et al. (1980) study. In addition to distinguishing characterological depressions on

the basis of treatment response, Akiskal et al. (1981) compared the groups on Schneider's depressive typology and developmental object loss. Interestingly, while Schneiderian personality features were highly characteristic of the subaffective dysthymic group, they were significantly less characteristic of the character spectrum and chronic secondary groups. Moreover, whereas family history of depression was strongest for the subaffective dysthymic group, the character spectrum group had significantly greater rates of familial alcoholism, familial assortative mating, and developmental object loss. These outcomes further substantiated Akiskal et al.'s (1980) conclusion that subaffective dysthymia may be primarily affective whereas character disorders may be primary for the character spectrum group.

In his 1983 report, Akiskal summarized his findings regarding the heterogeneity of chronic depression. He divided chronic depressions into three major groups: (a) primary depressions with residual chronicity, usually of late onset and following one or more primary major depressive episodes; (b) chronic secondary dysphorias, having a variable onset age and occurring in the context of preexisting and incapacitating nonaffective disorders; and (c) characterologic depressions, having insidious and early developmental onset and fluctuating course. He additionally concluded that characterological depressions appeared to

consist of at least two subgroups: (a) character-spectrum disorders which reflected primarily characterological pathology, and (b) subaffective dysthymic disorders where the personality disturbances appeared secondary to frequent episodes of low-grade endogenous depression.

Following Akiskal's (1983) recommendations on distinguishing various subgroups of patients receiving the diagnosis of dysthymia, two significant changes in the dysthymia diagnosis delineated in DSM-III-R (1987) were: (a) excluding patients whose chronic depressive conditions began within two years of a major affective episode, and (b) introducing primary-secondary and early-late onset subtype distinctions. Noting that Akiskal's (1983) typology did not include late-onset primary dysthymia, Klein, Taylor, Dickstein, and Harding (1988a) examined the prevalence of late-onset primary dysthymia in outpatients and explored the validity of the early-late onset distinction by comparing groups of early and late onset primary dysthymics on demographic, clinical, and familial characteristics and short-term outcome.

Subjects included 32 early-onset and 11 late-onset primary dysthymics, diagnosed according to DSM-III-R (1987) criteria. As part of a larger study, 550 consecutive outpatients at a community mental health center and a university-based clinic completed the General Behavior Inventory (GBI), a screening inventory for chronic and

recurrent unipolar and bipolar affective conditions. One hundred seventy-seven patients were selected through a stratified random sampling method and administered a structured diagnostic interview.

All patients received structured diagnostic interviews which elicited all information necessary to derive DSM-III-R (1987) diagnoses of dysthymia, as well as information relating to assessment of eating disorders and borderline, schizotypal, and antisocial personality disorders. Based upon Akiskal, King (1981), and Akiskal (1983), the following groups of traits were assessed: (a) quiet, introverted, passive, non-assertive; (b) gloomy, pessimistic, serious, incapable of fun; (c) self-critical, self-reproaching, self-derogatory; (d) skeptical, hypercritical, hard to please; (e) conscientious, responsible, self-disciplined; (f) brooding, given to worry; (g) preoccupied with negative events, feelings of inadequacy and personal short-comings to the point of morbid enjoyment.

Severity of depression was assessed by rating all DSM-III (1980) major depression and melancholia symptoms during the worst period in the index episode. Ratings were summed up to yield an overall severity score. Data on psychopathology in all first-degree relatives over age 17 were systematically collected using the Family History Research Diagnostic Criteria (FH-RDC) interview guide.

Follow-up assessments were conducted six months after

entry into the study. Follow-up data were obtained for 73% of the early-onset and 82% of the late-onset dysthymics. All treatment received during the follow-up period was recorded but not controlled. The follow-up assessment included a semi-structured interview based on the Longitudinal Interval Follow-up Evaluation (LIFE). Seven measures of course and outcome were derived from the interview, including mean depression, mean global social adjustment, and mean Global Assessment Scale ratings across the follow-up period; depression, global social adjustment, and Global Assessment Scale ratings at six months; and whether or not the patient had recovered during the follow-up period.

The prevalence of late-onset dysthymia was 5.3%; whereas the rate of early-onset dysthymia was 10.3%. Except for age, with the late-onset group being older than the early-onset group, the demographic characteristics of both groups were similar.

The early-onset group reported having sought treatment more often than the late-onset group; however, the two groups did not differ with respect to severity of depression. The early-onset dysthymics were more likely to have experienced a superimposed major depressive episode, and a significantly greater proportion of early than late-onset dysthymics had a lifetime history of anxiety disorder. There were also trends for the early-onset subjects to have

higher lifetime rates of eating disorders and borderline or schizotypal personality disorders than late-onset subjects. The two groups did not differ with respect to lifetime substance abuse or levels of Schneiderian depressive personality traits. This finding appears to contradict Akiskal et al. (1981) where the subaffective dysthymic group reported significantly more Schneiderian depressive personality traits than the late-onset chronic depressive group. A closer look, however, reveals that in the Akiskal et al. (1981) study, early-onset dysthymia was divided into a subaffective dysthymic group and a character spectrum group. The findings of that report were that while Schneiderian traits were highly characteristic of the subaffective dysthymic group, they were uncharacteristic of the character spectrum group. When both groups were compared together in the early-onset group in the Klein et al. (1988a) study, the distinctiveness between subaffective dysthymia and character spectrum disorders was missed, and early- and late-onset dysthymics appeared similar with respect to Schneiderian traits.

The relatives of the early-onset subjects exhibited significantly higher rates of major affective disorder than the relatives of the late-onset subjects. During the follow-up period, the two groups received similar types and levels of psychotherapy and medication; however, almost half of the late-onset, but only a quarter of the early-onset,

dysthymics had recovered within six months of entry into the study. The late-onset dysthymics exhibited significantly lower mean depression ratings than the early-onset dysthymics both across the follow-up period and at the time of the six-month follow-up.

Klein et al. (1988a) concluded that the results of their study provided preliminary support for the validity of the early-late onset distinction in dysthymia and encouraged replication of these findings using direct interviews with relatives, a longer follow-up period, and studies of the psychosocial and biological correlates of these subtypes and their response to treatment.

Klein et al. (1988a) suggested that late-onset primary dysthymia appeared to more closely resemble episodic major depression than early-onset primary dysthymia. Therefore, Klein, Taylor, Dickstein, and Harding (1988b) endeavored to explore the distinctions between early-onset dysthymia and primary unipolar acute major depression. In this study Klein et al. (1988b) attempted to address the preliminary evidence that some forms of primary early-onset dysthymia resembled major affective illness with respect to phenomenology and sleep neurobiology (Akiskal et al., 1980). In an effort to more clearly understand the link between early-onset dysthymia and major affective disorder, Klein et al. (1988b) compared primary early-onset dysthymics with patients who had primary nonbipolar nonchronic major

depression on demographic, clinical, familial, personality and socioenvironmental characteristics and short-term course and outcome.

Subjects included 32 patients meeting DSM-III-R (1987) criteria for primary early-onset dysthymia and 35 patients meeting DSM-III-R (1987) criteria for nonbipolar nonchronic major depression. Subjects were drawn from the same subject pool and by the same method as in the Klein et al. (1988a) study.

With respect to sociodemographic variables, the two groups did not differ significantly on age, sex, race, marital status, education, or social class. The early-onset dysthymics obtained significantly higher GBI Depression scores and reported being depressed a significantly greater proportion of the past two years than the episodic major depressives. The early-onset dysthymics were rated as significantly more impaired on the GAS; however, the two groups did not differ on severity of depressive symptomatology as assessed by either the interviewer or the BDI. A comparison of rates of associated diagnoses indicated that the early-onset dysthymics were significantly more likely to receive diagnoses of borderline and/or schizotypal personality disorder and to exhibit current or past substance abuse than the episodic major depressives. Moreover, early-onset dysthymics exhibited significantly higher levels of Schneiderian depressive personality traits.

Early-onset dysthymics reported having significantly lower levels of social support, a higher level of chronic strain, and a higher level of global perceived stress than the nonchronic major depressives. Compared with the episodic major depressives, the early-onset dysthymics were significantly more likely to have a family history of major affective disorder, bipolar II disorder, nonbipolar depressive disorder, and antisocial personality. There were also trends for a higher proportion of dysthymics to have relatives who had been hospitalized for an affective disorder and to come from families where both parents had mood disorders. Moreover, a lower proportion of dysthymics had relatives with alcoholism than patients with nonchronic major depression. The two groups did not differ on family history of bipolar I disorder, schizophrenia, drug use disorder, and other psychiatric disorder, or loss of a parent through death, divorce, separation, or removal from the home prior to age 15. During the six-month follow-up period, a significantly lower proportion of early-onset dysthymics than episodic major depressives recovered. Compared with the major depressives, the dysthymics exhibited significantly poorer mean social adjustment and global functioning scores across the follow-up period.

Klein et al. (1988b) concluded that there was a close relationship between early-onset dysthymia and major affective disorder and that early-onset dysthymia may even

be a more severe form of affective disorder. Additionally, the results of their study suggested a relation between early-onset dysthymia and severe personality disorders; however, the direction of the relationship remained uncertain. They suggested the following possibilities in that regard: (a) chronic dysphoria is a consequence of the turbulent and unstable lives led by individuals with severe character pathology; (b) chronic depression with a childhood or adolescent onset interferes with normal social and emotional development, resulting in significant deficits in ego-function and interpersonal relationships; (c) primary early-onset dysthymia is a heterogeneous category that includes a subgroup of patients with primary affective disorder, and a subgroup with personality disorders and secondary dysphoria; (d) early onset dysthymia and severe personality disorder share common etiological processes; and (e) chronic depression and severe character pathology are independent dimensions.

To further understand the distinctiveness of early-onset dysthymia, Bloch, Shear, Markowitz, Leon, and Perry (1993) studied the defense mechanisms employed by early-onset dysthymics compared with panic disorder patients. Based on their clinical experience and the psychodynamic premises that predominant defense mechanisms in a given case would depend on the type of psychopathology under consideration, Block et al. (1993) formulated three

hypotheses: (a) dysthymic subjects and panic subjects would be similar in endorsing primarily lower-maturity defense mechanisms, (b) dysthymic subjects would use a pattern of defense mechanisms distinct from the pattern endorsed by panic subjects, and (c) dysthymic subjects would endorse more frequently than panic subjects four individual defenses which tend to handle anger and low self-esteem poorly: devaluation, passive aggression, projection, and hypochondriasis.

Subjects for the study were recruited from the outpatient Dysthymia and Anxiety Disorders Clinics of the Payne Whitney Clinic. Twenty-two subjects with the primary diagnosis of early-onset dysthymia and 22 subjects with primary panic disorder, diagnosed according to the DSM-III-R (1987) with structured diagnostic interviews were chosen for the study. Each subject underwent one 50-minute videotaped, psychodynamically oriented interview by trained psychoanalysts (10 psychiatrists and one clinical psychologist). Interviewers conducted confrontational interviews to elicit as many defense mechanisms as possible. Subsequently, the videotape was utilized by four psychiatrists and one graduate research assistant to rate defense mechanisms using the Defense Mechanism Rating Scales.

The Defense Mechanism Rating Scales groups individual defenses into seven hierarchial levels, producing a defense

mechanism profile, defense level scores, and an overall defense maturity score. The dysthymic subjects scored significantly higher than the panic subjects on the narcissistic, disavowal, and action defense levels and on individual defenses of devaluation, projection, passive aggression, hypochondriasis, projective identification, and acting out. Neither the dysthymic subjects' nor the panic subjects' overall defense maturity scores approached the mature range.

Bloch et al. (1993) concluded that dysthymic patients may display a characteristic defense mechanism profile when compared to patients with panic disorder. Dysthymic patients favored defenses that indicated conflict over directly confronting internal or external stressors. They externalized the source of conflict, experienced themselves as powerless, and demanded others' intervention to solve conflicts better dealt with by themselves. When they became frustrated that nothing effective happened, they alternatively turned their frustrations on themselves and others. By contrast, panic patients appeared to have conflicts involving guilt over negative affects and self-assertion, leading them to avoid guilt by turning negative feelings into positive feelings and diluting negative actions or experiences with their equal and opposite counterparts.

Bloch et al. (1993) suggested three possible models to

explain the correlation between dysthymia and characteristic defenses. First, dysthymia is a primary neurobiological mood disturbance, and the defense profile is compensatory; that is, the mood disorder produced characterological defenses. Second, the defense profile constitutes the primary disturbance, and the mood disorder is secondary; that is, depression is the consequence of using maladaptive defense mechanisms. Third, the mood disorder and defense profile are related to a third underlying problem, such as disturbance in self-esteem regulation distinct from depression itself.

From the perspective of Akiskal (1983), regarding the subdivision of early-onset dysthymia into subaffective dysthymia and character spectrum disorder, each of the models used by Bloch et al. (1993) could be plausible depending on the subtype distinction. For a patient experiencing subaffective dysthymia in which the disturbance may be primarily affective, the defense profile may be compensatory, producing characterological defenses. For a patient with a character spectrum disorder, the mood disorder and defense profile may be related to a personality disorder (e.g. borderline). Further discrimination between the subtypes of early-onset dysthymia (Akiskal, 1983) may have aided Bloch et al. (1993) in more clearly understanding defense mechanisms in dysthymic patients.

To explore further the distinction between major

depression and dysthymic disorder, Szadoczky, Fazekas, Rihmer, and Arato (1994) compared groups of patients with major depression and dysthymic disorder with respect to two groups of variables. Those variables were: psychosocial (demographic characteristics, loss and separation in childhood, family atmosphere in childhood, recent life events) and biological (family history for psychiatric disorders, dexamethasone suppression test (DST), and thyrotropin-releasing hormone (TRH) test). The purpose of their study was to determine whether any of those variables could differentiate the two course-patterns of major depression (chronic and nonchronic) and the two age-onset distinctive subgroups of dysthymic disorder (early and late onset.

The subject pool consisted of 180 inpatient and outpatient depressed patients, 71 nonchronic and 34 chronically major-depressed patients, and 75 dysthymic patients (39 of which were doubly depressed and 36 of which were pure dysthymics). The diagnosis was based on clinical interviews with the patient and with one of his or her close relatives. The interviews covered loss and separation experiences as well as childhood experiences. The severity of the depressive symptomatology was measured by the 21-item Hamilton Rating Scale for Depression (HRSD) and Zung Self-rating Scale for Depression (ZSSD). A dexamethasone suppression test was performed on all participants. In 42

patients (14 major-depressed patients with and 14 without a chronic course, and 24 double depressed patients) a thyrotropin-releasing hormone (TRH) test was carried out after a drug wash-out period of at least 14 days. Serum triiodothyronine (T3) and thyroxin (T4) levels, as well as serum thyroid-stimulating hormone (TSH) levels, were determined by radioimmunoassay.

Specifically regarding the dysthymic patients, in the early-onset group, significantly more patients had never married than in the late-onset group. Moreover, the number of years of education was significantly lower in the late-onset group. The two groups did not differ significantly with regard to the occurrence of affective disorders or any other psychiatric disorders among first-degree relatives. No significant difference was found between the two groups concerning the occurrence of loss or separation in childhood. However, patients with early-onset dysthymia characterized the family atmosphere in their childhood as more traumatic and conflict-ridden than patients with late-onset dysthymia. Moreover, significantly more patients with early-onset dysthymia had attempted suicide than those in the late-onset group. Alcohol and drug abuse occurred only in the early-onset group. There was no significant difference in the severity of the depressive symptomatology between the two groups.

With regard to the biological variables, the rate of

DST nonsuppressors was significantly higher in the early-onset group than in the late-onset group. However, there was no significant difference in the rate of nonsuppression between the two groups when patients with double depression (major depression superimposed upon dysthymia) were excluded. There were no statistically significant differences in the levels of T3, T4 and baseline TSH. Five out of the 24 dysthymic patients who underwent a TRH test showed blunted TSH responses to TRH. All five patients belonged to the early-onset group. Significantly more patients with early-onset dysthymia proved to be DST nonsuppressors than patients with late-onset dysthymia. Szadoczky et al. (1994) concluded that their results supported the validity of the early-late onset distinction of dysthymia.

Comorbidity of Dysthymia With Axis II Disorders

Alnaes and Torgersen (1989) examined personality traits and personality disorders among 298 outpatients with pure major depression, major depression combined with chronic depressive conditions (dysthymic or cyclothymic disorders) and pure dysthymic or cyclothymic disorders. The patients were interviewed by the Structured Clinical Interview for DSM-III (SCID-I) and the Structured Interview for DSM-III Personality Disorders (SIDP). Additionally, the Millon Clinical Multiaxial Inventory (MCMI) and the Basic Character

Inventory (BCI) were applied two months after the initial interviews. Finally, the Comprehensive Psychopathological Rating Scale-Depression Subscale (CPRS-D) was utilized.

The sample was divided into four groups: pure major depression, mixed depression/dysthymic-cyclothymic disorder, pure dysthymic-cyclothymic disorder, and a group comprised of mainly anxiety disorders. The mean number of diagnoses for each group was 1.8, 2.5, 2.3, and 1.4, respectively. Regarding the BCI personality trait scores, emotional instability, self-doubt, sensitivity, dependence, insecurity, and compliance were pronounced among patients with major depression/dysthymic-cyclothymic disorders and pure dysthymic-cyclothymic disorder. According to the MCMI results, borderline, avoidant, and passive-aggressive personality disorders were pronounced among patients with major depression/dysthymic-cyclothymic disorders and pure dysthymic-cyclothymic disorders. With respect to DSM-III (1980) Axis II, paranoid, histrionic, narcissistic, borderline, avoidant, and passive-aggressive personality disorder were particularly frequent among patients with major depression/dysthymic-cyclothymic disorder and pure dysthymic-cyclothymic disorder. These findings were striking, particularly since no distinction was made between early- and late-onset dysthymia, and cyclothymic patients were included. Even with less specificity, the dysthymic-cyclothymic and mixed major depression/dysthymic-cyclothymic

groups exhibited significantly more personality disturbance than the other two groups of subjects.

Alnaes and Torgersen (1989) questioned the utility of applying both a chronic affective disorder diagnosis and a personality disorder diagnosis, suggesting that the term dysthymic-cyclothymic referred more to the personality disorders than to the symptom disorders. They suggested, therefore, the abolition of the diagnosis of chronic affective disorders in favor of a personality disorder diagnosis which gives the most nuanced description of the more chronic aspects of the disorder.

Distinction between subtypes of dysthymia may yield a clearer understanding of what type of diagnosis would be most helpful to describe and treat depressive disorders. Perhaps early-onset dysthymia is primarily a mood disorder in some cases (subaffective dysthymia) or a secondary disturbance to a primary personality disorder. Further, a depressive personality disorder may arise from subaffective dysthymia. Alnaes and Torgersen (1989) showed a relationship between early-onset dysthymia and personality disorders; however, the direction of the association remained unclear.

Markowitz, Moran, Kocsis, and Frances (1992) investigated dysthymic disorder in relationship to other psychiatric and medical disorders for the following purposes: (a) to investigate the prevalence of dysthymic

disorder among general psychiatric outpatients, (b) to compare patterns of psychiatric and medical comorbidity in patients with and without dysthymic disorder, (c) to determine temporal relationships of ages of onset between dysthymic disorder and concurrent psychiatric or medical diagnoses, and (d) to assess relationships between research and clinical determination of dysthymic disorder diagnoses and in the influence of clinical diagnosis of the type and appropriateness of treatment received.

The subjects for the Markowitz et al. (1992) study were 90 outpatients at the Payne Whitney Clinic, an urban university psychiatric center. Subjects were interviewed with the Structured Clinical Interview for DSM-III Patient Version (SCID-P) and for Personality Disorders (SCID-II), and an instrument to assess Axis III diagnoses and Axes IV and V scores. Based on this interview, they determined whether subjects met criteria for DSM-III (1980) dysthymic disorder, Akiskal's dysthymic subtypes (Akiskal, 1983), and DSM-III-R (1987) dysthymia. Twenty-seven subjects fulfilled DSM-III (1980) criteria for dysthymic disorder. Using DSM-III-R (1987) criteria, 21 qualified for primary dysthymia, five secondary dysthymia, and one chronic major depression. Of DSM-III-R (1987) primary dysthymics, 14 had early onset, seven late; all five secondary dysthymics had late onset. Classification according to Akiskal's (1983) subtypes yielded three primary depressions with residual chronicity,

three chronic secondary dysphorias, and the remainder of insidious onset ("characterologic").

Dysthymics were more likely to meet criteria for major depressive disorder and social phobia than those without dysthymic disorder among outpatients. Dysthymic subjects suffered from significantly more Axis II diagnoses, such as self-defeating, avoidant, borderline, and dependent personality disorders. Comorbidity did not differ among dysthymics by DSM-III-R (1987) subtype. Markowitz et al. (1992) suggested that the Axis II findings may have revived the question of whether dysthymic disorder should be considered a personality disorder. Eighty-five percent of dysthymics had at least one Axis II diagnosis. They highlighted the fact that the personality disorders most strongly associated with dysthymic disorder shared definitional overlap with "chronic depressive" symptoms: avoidance, withdrawal, dependence, and self-destructive behavior. Therefore, they concluded that dysthymic disorder may still be diagnosed on Axis II under the guises of self-defeating, avoidant, borderline, and dependent personality disorders.

Pepper, Klein, Anderson, Riso, Ouimette, and Lizardi (1995) compared a group of outpatients with primary, early-onset dysthymia with outpatients with episodic major depression. The purpose of their study was: (a) to determine whether personality disorders were more common in

dysthymia than in other Axis I disorders, (b) to estimate the prevalence of Axis II comorbidity in dysthymia, and (c) to ascertain which specific personality disorders co-occur most frequently with dysthymia.

The subjects included 97 early-onset dysthymics, 56 patients with and 41 without a concurrent major depression and 45 patients with nonchronic major depression. The SCID(2) was used to diagnose Axis I disorders, and the revised version of the Personality Disorder examination (24) was used to assess Axis II disorders. In order to assess the severity of depressive symptoms, the Hamilton Depression Rating Scale was administered at the time of both the SCID and Personality Disorder Examination interviews. In the first session with the Hamilton Depression Scale, patients were rated for the worst week in the current major depressive episode or for the worst week in the past month for patients who were not in a current major depression. The second administration of the Hamilton Depression Scale focused on the past week in order to assess current level of depression. Knowledgeable informants were interviewed according to an informant version of the Personality Disorder Examination.

When dysthymic patients were compared with patients with episodic major depression, a significantly greater proportion of dysthymic patients than patients with episodic major depression met criteria for at least one personality

disorder. With regard to specific Axis II conditions, dysthymic patients exhibited significantly higher rates of borderline, histrionic, avoidant, and self-defeating personality disorder than patients with episodic major depression. Moreover, dysthymic patients received significantly higher dimensional scores for all 13 personality disorders than the patients with episodic major depression. When current depression and length of illness were statistically controlled, the two groups still differed significantly on the rate of any Axis II disorder. With respect to informant reports, a significantly greater proportion of dysthymic patients than patients with episodic major depression had at least one personality disorder.

Pepper et al. (1995) suggested that their findings underscored the heterogeneity of personality styles of dysthymic patients. While many dysthymic patients were stably dysphoric, introverted, and inhibited, others exhibited marked affective lability (although their predominant affective tone was depressed) and impulsivity. The former group corresponded closely to the constructs of subaffective dysthymia (Akiskal, 1983) and depressive personality (Klein, 1990, and Phillips, Gunderson, Hirschfeld, & Smith, 1990), while the latter group was characterized as having character spectrum disorder (Akiskal, 1983).

Although the Pepper et al. (1995) findings indicated

that early-onset dysthymia was associated with a higher rate of Axis II comorbidity, Pepper et al. (1995) suggested that to understand the nature of the association it would be necessary to determine the nature of the processes underlying the association between dysthymia and the personality disorders. They suggested a number of potential models: (a) early-onset chronic depressions predispose individuals to develop personality disorders; (b) dysthymia is often a secondary complication of preexisting character pathology; (c) early-onset dysthymia is heterogeneous, with subaffective and character spectrum subtypes; and (d) dysthymia and many personality disorders arise from shared, or overlapping, etiological processes. Pepper et al. (1995) suggested that family and follow-up studies may be useful in testing these alternative explanations.

In order to gain more insight into early home environment in dysthymia, Lizardi, Klein, Ouimette, Riso, Anderson, and Donaldson (1995) compared the childhood home environments in subjects with early-onset dysthymia, episodic major depression, and normal controls. Specifically, two questions were addressed: (a) is early-onset dysthymia associated with reports of a disturbed childhood home environment; and (b) can these reported adverse early experiences account, at least in part, for the differing clinical manifestations of dysthymia and major depression?

Subjects for the Lizardi et al. (1995) study included 97 outpatients with DSM-III-R (1987) primary early-onset dysthymia, 45 outpatients with DSM-III-R (1987) nonchronic major depression, and 45 normal controls from the community with no lifetime history of Axis I disorder. All participants were administered the Structured Clinical Interview for DSM-III-R (1987), the Modified Hamilton Rating Scale for Depression (MHRSD), and the revised version of the Personality Disorder Examination. The childhood home environment was assessed using the Early Home Environment Interview (EHEI) and the Parental Bonding Instrument (PBI). The EHEI is a structured interview, and the PBI is a self-report measure of an individual's perceptions of his or her parents' behavior through age 16 regarding care and overprotection. Participants additionally completed the Inventory to Diagnose Depression (IDD), also a self-report measure, to assess the severity of depressive symptomatology at the time the PBI was administered.

With regard to home environment variables, a significantly greater proportion of early-onset dysthymic patients than normals reported having been physically and sexually abused. In addition, patients with episodic major depression reported significantly greater sexual abuse than normals. Patients with early-onset dysthymia reported having had significantly poorer relationships with both their mothers and fathers and receiving significantly less

care and greater overprotection from both their mothers and fathers than normals. In addition, patients with episodic major depression reported a significantly poorer relationship with their fathers and significantly greater maternal overprotection than normals. Finally, patients with early-onset dysthymia reported having had a significantly poorer relationship with, and receiving significantly less care from, both their mothers and fathers than patients with episodic major depression.

With respect to the effects of comorbid diagnoses, patients with early-onset dysthymia exhibited a significantly higher rate of borderline personality disorder than patients with episodic major depression. In addition, many of the childhood home environment variables were significantly correlated with borderline and antisocial traits. To determine whether the differences between patients with early-onset dysthymia and episodic major depression could be attributed to the effects of comorbid borderline and antisocial personality disorders, the data were reanalyzed after excluding the 24 early-onset dysthymia patients with a borderline or antisocial personality disorder diagnosis. All of the significant differences between patients with dysthymia and major depression and normals were still significant after the borderline and antisocial patients were excluded. Lizardi et al. (1995) concluded that their study provided suggestive evidence for

the role of the childhood home environment in the development of early-onset dysthymia, indicating that patients with early-onset dysthymia reported having had much poorer relationships with both parents than patients with episodic major depression. Of importance was that the pattern of findings was similar using both interview and self-report methodologies. Moreover, the possibility that these results could be accounted for by comorbid borderline and antisocial personality disorder was ruled out because identical findings were obtained after excluding all dysthymic patients with borderline or antisocial personality.

Depressive Personality as a Distinct Personality Disorder

Klein (1990) endeavored to study depressive personality as a broad personality type or syndrome similar to the DSM-III-R (1987) Axis II disorders. As a starting point for defining the syndrome, he used Schneider's (1958) description of the depressive personality, as formalized by Akiskal (1983). Among the issues addressed by Klein (1990) were: (a) the interrater reliability, internal consistency, and test-retest stability of Akiskal's (1983) criteria; (b) the effect of patients' mood states on the interview assessment of the depressive personality, (c) the convergent and discriminant validity of the depressive personality, and

(d) the relation between the depressive personality and the mood disorders, particularly dysthymia.

The method in this 1990 study is the same method used by Klein et al. (1988a and 1988b). Subjects included 177 adult outpatients from a community mental health center and a university-based clinic. They were drawn from a larger series of 550 consecutive admissions who had completed the revised General Behavior Inventory (GBI), a measure of chronic, intermittent, hypomanic and depressive symptoms, before their intake interview. All subjects received a structured diagnostic interview based on the Schedule for the Affective Disorders and Schizophrenia. The interview was expanded to derive DSM-III (1980) diagnoses, collect additional information on chronic mood disorders (including all data necessary to derive DSM-III-R (1987) dysthymia subtype diagnoses), and assess eating disorders, borderline and schizotypal personality disorders, and Schneider's (1958) construct of the depressive personality.

Akiskal's (1983) criteria included seven groups of depressive personality traits: (a) quiet, introverted, passive, and nonassertive; (b) gloomy, pessimistic, serious, and incapable of fun; (c) self-critical, self-reproaching, and self-derogatory; (d) skeptical, hypercritical, and hard-to-please; (e) conscientious, responsible, and self-disciplined; (f) brooding and given to worry; and (g) preoccupied with negative events, feelings of inadequacy,

and personal shortcomings. After the diagnostic interview, the subjects were administered the Family History Research Diagnostic Criteria (FHRDC) interview guide to assess psychopathology in all first-degree relatives over age 17. After completing the interview, the subjects were given a battery of self-report inventories which was designed to assess depression (Beck Depression Inventory), personality (Depressive Experiences Questionnaire, the Dysfunctional Attitudes Scale, the Attributional Style Questionnaire, the Multidimensional Personality Questionnaire, and the Eysenck Personality Questionnaire, extraversion scale), and stressful life events (the Psychiatric Epidemiology Research Interview). Follow-ups six months after the intake evaluation were completed with 90 percent of the sample. The follow-up assessment included a semistructured interview based on the Longitudinal Interval Follow-Up Evaluation. After completion of the interview, the section of the initial diagnostic interview to assess depressive personality traits was readministered.

In his 1990 study, Klein acknowledged that in order for the depressive personality construct to be useful, rather than redundant, it must not be entirely subsumed by existing mood disorder categories. From that perspective, he compared patients with and without depressive personality on seven diagnostic and clinical variables. A significantly greater proportion of patients who met the criteria for

depressive personality received a DSM-III (1980) diagnosis of dysthymic disorder. In addition, a significantly greater proportion of patients with depressive personality met DSM-III-R (1987) criteria for primary, early-onset dysthymia. A significantly higher proportion of relatives of patients with than without depressive personality had a history of bipolar disorder. In addition, the rate of family members hospitalized for affective disorder was significantly higher among patients with than without depressive personality. Patients with a depressive personality also exhibited significantly higher levels of stress reactivity, self-criticism, and depressive attributions, and a significantly lower level of extraversion, than patients without a depressive personality. In addition, patients who met criteria for depressive personality exhibited a trend for a higher level of dysfunctional attitudes than patients who failed to meet criteria.

Although dysthymia and the depressive personality were significantly associated, only 30% of patients who met one of these sets of criteria met criteria for both. Specifically, 49% of patients with depressive personality met criteria for DSM-III (1980) dysthymic disorder, and 44% of DSM-III (1980) dysthymics met criteria for depressive personality (see Figure 2). Similarly, only 27% of patients who met criteria for either depressive personality or DSM-III-R (1987) primary, early-onset dysthymia met criteria for

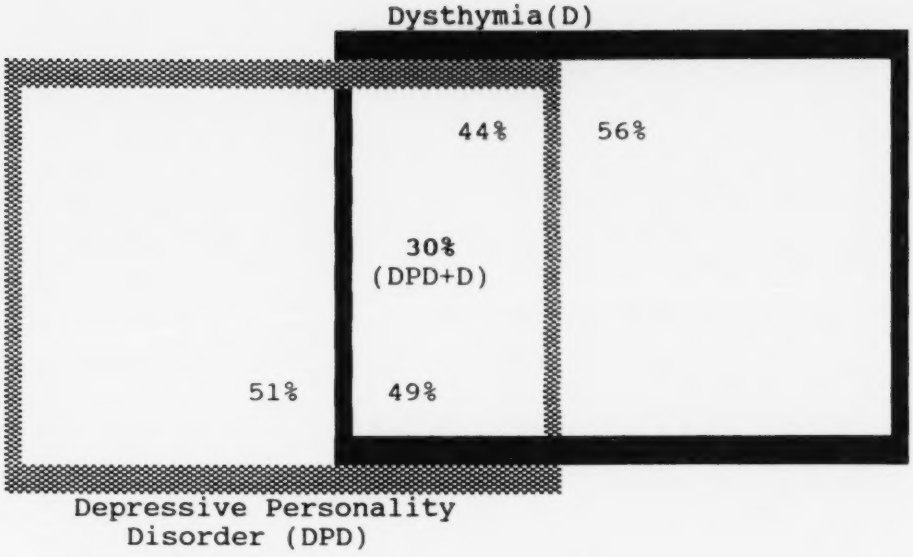

Figure 2. Overlap of depressive personality disorder and dysthymia diagnoses as described in "Depressive personality: Reliability, validity, and relation to dysthymia" by D. N. Klein, 1990. Journal of Abnormal Psychology, 99(4), p. 416.

both. Further, 34% of patients with depressive personality met criteria for DSM-III-R (1987) primary, early-onset dysthymia, and 56% of DSM-III-R (1987) primary early-onset dysthymics met criteria for depressive personality (see Figure 3). The data suggested that although dysthymia and the depressive personality overlapped, they may be distinct constructs.

To further explore the distinctiveness of the depressive personality construct, Klein (1990) compared

patients who met criteria for depressive personality but not dysthymia to those meeting criteria for dysthymia but not depressive personality. Dysthymics obtained significantly higher scores on the GBI-D than patients with depressive personality. In addition, dysthymics exhibited significantly higher levels of depressive symptoms in the six-month follow-up interview than did patients with depressive personality. Dysthymics also exhibited a significantly higher rate of nonbipolar depression in relatives than patients with depressive personality.

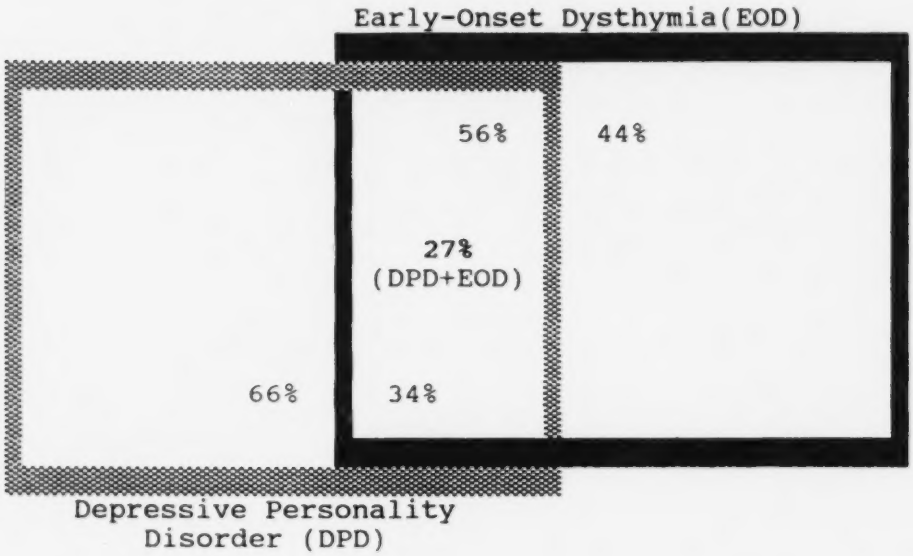

Figure 3. Overlap of depressive personality disorder and early-onset dysthymia diagnoses as described in "Depressive personality: Reliability, validity, and relation to dysthymia" by D. N. Klein, 1990. Journal of Abnormal Psychology, 99(4), p. 416.

Finally, there was a trend for the dysthymics to exhibit a higher rate of borderline personality disorder than the patients with depressive personality.

To further examine the discriminant validity of the depressive personality, patients with and without depressive personality were compared on a series of non-mood disorder variables that could potentially overlap with, but ought to be distinguishable from, the construct. First, the groups were compared on diagnoses of borderline and schizotypal personality disorders and on lifetime anxiety, eating, and substance-use disorders in order to determine whether the depressive personality could be distinguished from these conditions. Second, to explore further the relation between the depressive personality and nonaffective psychopathology, the groups were compared on rates of alcoholism and antisocial personality in relatives. These analyses addressed the possibility that the depressive personality is an alternative expression of certain nonaffective disorders or a nonspecific reaction to familial disturbance. Finally, the groups were compared on the PERI Life Events scale to determine whether the depressive personality is merely a form of demoralization associated with major life stressors. A significantly greater proportion of patients with than without depressive personality received a diagnosis of schizotypal personality disorder. The groups did not differ significantly on rates of borderline personality, anxiety,

eating, and substance-use disorders, rates of relatives with alcoholism and antisocial personality, and the PERI Life Events scale.

Klein (1990) concluded that his study provided relatively strong support of the convergent validity and discriminant validity of the depressive personality construct. Moreover, he suggested his findings provided preliminary support for recent criticisms that the depressive personality differs from and is incompletely covered by existing mood disorders categories and that it is a less symptomatic condition than that which is defined by DSM-III (1980) and DSM-III-R (1987) dysthymia. Klein (1990) suggested that if further work supports the validity of the depressive personality, it may be necessary to reevaluate the place of dysthymia in the nosological system. He suggested that among the possibilities to be considered were: (a) including separate dysthymia and depressive personality categories; (b) attempting to combine the early-onset dysthymic and depressive personality categories and restricting dysthymia to adult-onset cases; and (c) including the more symptomatic cases, which often meet the criteria for double depression as a subtype of major depression and adding a depressive personality category for less symptomatic cases.

From the perspective of Akiskal et al. (1981) another explanation may be plausible regarding the place of

dysthymia and depressive personality in the nosological system. Since in the Akiskal et al. (1981) study Schneiderian features were highly characteristic of the subaffective dysthymic group but uncharacteristic of the character spectrum group, perhaps dysthymic patients in the subaffective dysthymic group may be more properly placed in the depressive personality category, while the character spectrum group would remain in the early-onset dysthymic category. Alternatively, patients with depressive personality disorder may additionally experience depressive symptomatology that meet the criteria for early-onset dysthymia.

Klein and Miller (1993) attempted to replicate the Klein (1990) study with a large group of college students. One hundred eighty-five subjects were selected on the basis of a battery of screening inventories designed to identify persons exhibiting features of a number of Axis I and II disorders. The battery included the General Behavior Inventory depression and hypomania scales, which assess chronic and recurrent affective symptoms and personality traits across the full range of severity; the Physical Anhedonia Scale, which assesses anhedonia as a personality trait; and the perceptual Aberration-Magical Ideation Scale, which identifies subjects with a broad range of affective, schizotypal, and borderline features.

The subjects received a structured diagnostic interview

based on the Schedule for Affective Disorders and Schizophrenia, and items encompassing Akiskal's criteria (as derived from Schneider, 1958) for depressive temperament were included. The Family History Research Diagnostic Criteria interview was also administered to assess psychopathology in all first-degree relatives over age 17.

Using a cutoff of six or more groups of traits to define depressive personality, 36 subjects with and 149 subjects without depressive personality emerged. Relative to mood disorders, the subjects with depressive personality exhibited significantly higher rates of current mood disorder, life-time mood disorder, major depression, and dysthymia than the subjects without depressive personality. However, the overlap between depressive personality and the mood disorders was modest. Only 22% of the subjects with depressive personality had lifetime histories of major depression, and only 19% had lifetime diagnoses of dysthymia. Overall, 39% of the subjects with depressive personality had no lifetime history of any form of DSM-III (1980) mood disorder. With respect to non-mood disorders, depressive personality was marginally significantly associated with schizotypal personality disorder. However, it was not significantly associated with panic disorder, alcohol or drug abuse or dependence, conduct disorder, or borderline personality disorder. The family history data revealed that the proportion of first-degree relatives with

a history of affective disorders was significantly higher for the subjects with depressive personality. Moreover, there was a significantly higher rate of major depression in the relatives of the subjects with depressive personality.

As in Klein's (1990) study, depressive personality overlapped with dysthymia; however the magnitude of the association was modest. Klein and Miller (1993) concluded that their findings supported their previous conclusion that although depressive personality and dysthymia were overlapping constructs, they were not isomorphic and that depressive personality was not completely subsumed by existing mood disorders categories. Moreover, the Klein (1990) and Klein and Miller (1993) investigations suggested that DSM-III-R (1987) may fail to provide for many individuals who experience troubling depressive personality traits that may not be severe enough to meet the criteria for dysthymia. Therefore, the addition of depressive personality to DSM-IV (1994) may be warranted.

Furukawa and Sumita (1992) proposed a cluster analytic subclassification of chronic affective disorders. As part of a prospective study of chronic affective disorder patients who received long-term maintenance alone or in conjunction with prophylactic treatment, Furukawa and Sumita (1992) performed a mathematical cluster analysis of such patients with regard to symptom data. The derived clusters were then validated by retrospectively collected

psychosocial variables. Three Hundred Thirty-Five patients who visited the outpatient or inpatient sections of the Department of Psychiatry of a hospital in Japan between January and June 1990 and who met the following criteria were chosen as subjects for the study: (a) more than two years since the onset of an affective disorder, and (b) the patient had no period of more than two months during which he or she was asymptomatic without treatment since the onset of the affective disorder.

Present as well as past episodes were assessed and diagnosed by a modified form of the Schedule for Affective Disorders and Schizophrenia-lifetime version. The severity of the present depressive status was measured by the Hamilton Rating Scale for Depression. Personality factors were assessed by a battery containing the Yatabe-Guilford Personality Test (YBPA) and the Japanese version of the Maudsley Personality Inventory (MPI). The YGPT measures 12 personality factors of depression, cyclic tendency, inferiority feelings, nervousness, lack of objectivity, lack of cooperativeness, lack of agreeableness, general activity, rhathymia, thinking extraversion, ascendance, and social extraversion. The Japanese MPI provides a lie scale in addition to the original extroversion and neuroticism scales. The patients were told to "try to disregard the illness when answering the questions and answer yes or no according to how you would feel or behave when you were your

usual self." The social functions of the patients in work, leisure, marital, parental, family unit and extended family spheres were rated by the Social Adjustment Scale Self-Report (SAS-SR). Of the 81 patients, 5 declined to cooperate, and 36 did not fulfill the inclusion criteria; therefore, the results of the study involved the remaining 40 subjects.

Symptom data were analyzed by complete linkage hierarchical cluster analysis. Three groups of patients were identified as a result of analysis of the 40 symptom data by the SADS-L. Group A, a psychotic subtype, consisted of mainly men, with a young onset and a relatively short duration of the disorder. The most salient feature of this subtype was the lifetime presence of psychotic features. It also showed suicidal tendency, psychomotor symptoms and incapacitation more frequently than the other two groups. Group B, a late-onset female subtype consisted of mainly women with a late-onset and long duration of the disorder. Appetite disturbance was almost always seen but suicidal tendency was observed only in a third of the group. Psychomotor symptoms were frequent but seldom led to incapacitation. Group C, the depressive personality subtype, consisted mainly of men, with the earliest onset and the longest duration of the disorder. Psychomotor symptoms were infrequent but suicidal tendency and incapacitation were observed in more than two thirds of the

subjects. Early object loss was seen in about half of the patients, and the MPI neuroticism score was high. Early-onset for Furukawa and Sumita (1992) referred to onset around age 30 years, and late-onset referred to about 50 years, in contrast to DSM-III-R (1987), which demarcates these subdivisions at the age of 21.

Schrader (1994) sought to discover whether depression scores varied over time in the chronically depressed, when measures of personality and dysfunctional cognitions also varied. He postulated that decreasing trait neuroticism with decreasing severity of depression would suggest that the abnormal personality functioning found in chronic depression is determined by the abnormal affective state. However, constantly abnormal personality and cognitive style with varying depression severity would suggest that personality and dysfunctional thinking help maintain chronic depression independent of the severity of affective symptoms. In the Schrader (1994) study, a group of patients with chronic depression was followed prospectively with respect to depression severity, several variables reflecting personality, and the presence of negative cognitions. They hypothesized that if chronic depression shared features of an affective disorder, then any changes in depressive severity occurring over time should be accompanied by consistent changes in personality variables and variables reflecting negative cognitions.

Patients were recruited over a two-year period by a review of all case notes at an outpatient psychiatric clinic of a hospital. Patients were also recruited from newspaper articles inviting participation in the study. This group was required to be in treatment for chronic depression by a psychiatrist or a general practitioner, or both. Patients were interviewed by using the Structured Clinical Interview for DSM-III and the Hamilton Rating Scale. They were also asked to complete a series of questionnaires: the Maudsley Personality Inventory (MPI) from which measures of neuroticism and extroversion were derived; the Inventory for Depressive Symptomatology (IDS), a self-rated depression severity scale; the Dysfunctional Attitudes Schedule (DAS); and the Hopelessness Scale (HS). Patients were asked by mail 12 months later to complete the questionnaires again. Patients were instructed to respond to the items on the DAS and MPI as they would "usually" feel.

According to the Structured Clinical Interview for DSM-III, 67% of the patients were diagnosed with dysthymic disorder, 36% were diagnosed with major depression, and 31% had diagnoses of both major depression and dysthymic disorder. A total of 52% had other nonaffective psychiatric diagnoses. Of the initial group, 69 patients could be followed. The followed group was similar to the nonfollowed group, with the exception that the followed group was significantly older than the group who was not followed.

There was a significant difference in IDS depression severity scores over time, with depression scores being 16% lower at follow-up. There was also a significant decline in HS scores occurring over time. There were no significant changes in MPI neuroticism or extroversion scores or DAS scores.

To determine whether the change in depression severity had occurred predominantly in patients with both dysthymic disorder and major depression, changes in patients with double depression were compared with changes in patients with dysthymic disorder alone. Patients with double depression showed no significant changes in neuroticism, extroversion, dysfunctional attitudes, or hopelessness, although there was a significant fall in IDS score. For patients with dysthymic disorder alone, there were no significant changes in any measure including depression severity.

Schrader (1994) concluded that although severity of depression changed over time, personality measures remained unaffected. Moreover, he suggested that the relative stability of dysfunctional attitudes may have indicated that negative cognitions had trait-like qualities in the chronically depressed. He further suggested that patients with chronic depression may have had depressive episodes superimposed over persisting traits of neuroticism, introversion, and dysfunctional thinking. Finally, Schrader

(1994) proposed that his findings may support the development of a depressive personality category.

For the purpose of providing evidence for validity and discriminability of depressive personality disorder, Gunderson, Phillips, Triebwasser, and Hirschfeld (1994) developed a diagnostic interview to assess depressive personality. The original draft of the Diagnostic Interview for Depressive Personality contained 32 characteristics attributed to depressive personality disorder that were gleaned from clinical and theoretical literature about the disorder. An effort was made to include characteristics that covered the different spheres in which personality should be assessed, namely, interpersonal, functional, cognitive/intrapsychic, and behavioral. Among these are nine traits, several of which are combined, that define the seven criteria for depressive personality disorder in DSM-IV (1994) appendix B.

Interrater reliability was assessed in a group of 16 patients obtained by referrals from the outpatient and inpatient practices of colleagues. An additional group of 67 subjects was then recruited to evaluate other psychometric properties of the interview. Fifty-four subjects with early-onset, longstanding mild depressive features were recruited by advertising in a local newspaper and asking clinicians on the staff of McLean Hospital, Belmont, MA, for referrals. Twenty-nine of these subjects

were outpatients and 25 were not patients. The other 13 subjects were normal comparison subjects recruited by asking friends, relatives, and fellow employees of the research staff to be interviewed. All subjects were interviewed by one clinician with the Diagnostic Interview for Depressive Personality. Factor analysis was done on the component traits of the Diagnostic Interview for Depressive Personality from a sample of 526 subjects who participated in the DSM-IV mood disorders field trial.

The interrater reliability for the total score on the Diagnostic Interview for Depressive Personality was .97, and the reliability of the interview for diagnostic placement, once the threshold score was established, was also good. The test-retest reliability for the 32 subjects given a second Diagnostic Interview for Depressive Personality about a year after the first (by a different interviewer) indicates moderate reliability (r = .69).

After establishing the reliability of rater's judgments about the likelihood of depressive personality disorder, the study group was divided into a subgroup of 27 subjects who were considered likely to have depressive personality disorder (scoring 4 or 5 on the likelihood scale) and a subgroup of 23 who were considered unlikely to have the disorder (scoring 1 or 2 on the scale). A test comparison of the mean scores of the likely and unlikely subgroups on the 32 traits on the Diagnostic Interview for Depressive

Personality revealed significant differences on most traits. Differences between the groups failed to reach significance on only three traits: conscientious, hypochondriacal, and critical of others. In a later revision of the interview, the first two of these traits were omitted.

To address the issue of possible overlap between depressive personality disorder and Axis I depression, Gunderson et al. (1994) used Pearson correlations between the total score on the Diagnostic Interview for Depressive Personality and the Hamilton Depression Scale score and the major depression items of the SCID. The correlation between the total interview score and the total score on the Hamilton Depression Scale was only .20. Only six traits on the diagnostic interview were significantly correlated with the Hamilton Scale score: gloomy, bitter, remorseful, difficulty having fun, passive, and negative reactivity. Of the correlations between the total score on the interview and the independently assessed major depression items on the SCID, only one was significant: total interview score and the low self-esteem item of the SCID.

In the course of the development of the Diagnostic Interview for Depressive Personality, two of the traits on the interview, hypersensitivity and low self-esteem appeared to have component parts that deserved to be assessed separately. As a result, hypersensitivity was divided into its two component probes, hypersensitivity to criticism and

hypersensitivity to rejection. Sensitivity to rejection could discriminate between the subjects likely and unlikely to have depressive personality disorder, whereas hypersensitivity to criticism could not. Low self-esteem was also divided into its two components, feeling unlikable and feeling inadequate. Feeling inadequate was found to discriminate subjects likely and unlikely to have depressive personality disorder, whereas feeling unlikable did not.

The components of the interview were grouped into the four sections on the basis of a principal-components factor analysis. The factors to emerge were: depressive/negativistic, introversion/tense, unassertive/passive, and masochistic. It appeared that the threshold for identifying persons judged likely to have the enduring, early-onset group of traits considered to represent a depressive personality disorder was a total score of 42 out of the possible 60 for the revised interview. This cutoff correctly classified 87% of the 67 subjects and produced only three false negatives and six false positives. A copy of the Diagnostic Interview for Depressive Personality (DID) developed by Gunderson et al. (1994) is included in the Appendix.

Gunderson et al. (1994) concluded that their results offered reassurance that most of the traits on the Diagnostic Interview for Depressive Personality had low correlations with indexes of depressed mood or major

depressive disorder. Further, although the traits on the interview could be expected to correlate with the criteria for dysthymia, many depressive personality disorder traits were cognitive, intrapsychic, and interpersonal, in contrast to the symptoms used to define DSM-III-R (1987) and DSM-IV (1994) dysthymic disorder, which are largely somatic.

The DSM-IV Mood Disorders Field Trial was initiated based on the deliberations of the Mood Disorders Work Group and reported by Keller, Klein, Hirschfeld, Kocsis, McCullough, Miller, First, Holzer, Keitner, Marin, and Shea (1995). The purpose of the study was to: (a) develop a nosology of mood disorders based on longitudinal course; (b) refine the criteria for dysthymia; and (c) evaluate the need for additional categories for mild, episodic depressive conditions.

The DSM-IV Mood Disorders Field Trial obtained data from five sites: Butler Hospital, Brown University School of Medicine; the State University of New York at Stony Brook; the University of Texas Medical Branch at Galveston; Virginia Commonwealth University, and the Payne Whitney Clinic, Cornell University Medical College. Subjects were 524 inpatients and outpatients who met the following inclusion and exclusion criteria: Patients were included if they reported depressed mood and at least two of the associated symptoms of DSM-III-R (1987) major depression or dysthymia, were at least 18 years old, and were English-

speaking. Patients were excluded if they reported history of psychosis, mania or hypomania, severe chronic or life-threatening medical illness, mental retardation, or medical or neurological etiology for depression, including substance abuse.

The initial evaluation included the Structured Clinical Interview for DSM-III-R (SCID) and a checklist assessing 31 depressive symptoms during the past month, as well as several additional interview and self-report measures. In order to provide more detailed information on the longitudinal course of major depression, a course-based classification system was developed to supplement the traditional approach to classification. This system was based on three key components: the presence or absence of antecedent dysthymia; single versus recurrent episodes; and, for recurrent major depression, whether or not there was full recovery between the two most recent episodes. These three factors were combined to yield six course patterns. The six course patterns, along with the frequency of each of the course types in 349 subjects with current major depression, are as follows: (a) single episode with antecedent dysthymia (n = 31, 8.9%); (b) single episode without antecedent dysthymia (n = 77, 22.1%); (c) recurrent, with antecedent dysthymia, with full interepisode recovery (n = 13, 3.7%) (d) recurrent, with antecedent dysthymia, without full interepisode recovery (n = 90, 25.8%); (e)

recurrent, without antecedent dysthymia, with full interepisode recovery (n = 68, 19.5%); and (f) recurrent, without antecedent of dysthymia, without full interepisode recovery (n = 66, 18.9%). Finally, there was a seventh category, unspecified, for cases which could not be otherwise classified (n = 4, 1.1%).

Keller et al. (1995) suggested that dysthymia criteria may lack discriminant validity with respect to major depression, which may result from the overlap in symptoms between the two criteria sets. To evaluate the criteria, they identified 193 cases in the Field Trial sample who met all of the course criteria for dysthymia included in DSM-III-R (1987) and examined the frequencies of all the symptoms included in the DSM-III (1980) and the DSM-III-R (1987) criteria for dysthymia. Keller et al. (1995) discovered that in patients meeting course criteria for dysthymia, cognitive and social-motivational symptoms predominated while vegetative and psychomotor symptoms were less common.

Subsequently, Keller et al. (1995) explored whether the symptom criteria for dysthymia could be modified to facilitate the discrimination between dysthymia and major depression. For this purpose, they selected a group of subjects who met DSM-III-R (1987) criteria for dysthymia but had no lifetime history of major depression and a group of subjects with recurrent major depression without antecedent

dysthymia. They compared the groups on the frequency of all items on the depressive symptom checklist. The symptoms that distinguished the groups were more common among subjects with major depression than dysthymia. Moreover, there was a tendency for somatic/vegetative symptoms to distinguish the groups better than cognitive/affective symptoms. The major depressives exhibited significantly higher rates for 7 of the 12 somatic/vegetative, but only 4 of the 19 cognitive/affective symptoms. Keller et al. (1995), therefore, suggested that content validity of the criteria could be increased by reintroducing a number of symptoms that had been discarded from the DSM-III (1980), such as social withdrawal, loss of interest, and irritability. Moreover, they suggested that the boundary between major depression and dysthymia might be clarified by increasing the emphasis on somatic/vegetative symptoms in the criteria for major depression.

Although evaluation of a depressive personality disorder was not originally part of the Field Trial, the sample, methods, and questions addressed were relevant to the issue; therefore, measures of depressive personality disorder were added, and the results were reported by Hirschfeld and Holzer III (1994). Instruments which were added to the battery were Diagnostic Interview for Depressive Personality, Dysfunctional Attitudes Scale, Social Adjustment Scale Self-Report, and the Rand Medical

Outcome Study Short-Form General Health Survey.

Three definitions of depressive personality were used in its diagnosis: (a) at least five of the seven proposed DSM-IV (1994) criteria for depressive personality disorder (214 subjects); (b) the Akiskal modification of the Schneider criteria (160 subjects); and (c) a cutoff score of 37 on the Diagnostic Interview for Depressive Personality (196 subjects). Forty-five percent of those meeting one definition for depressive personality disorder met all three definitions.

Of the 354 subjects with current major depression, 45% had comorbid depressive personality disorder, and 58% of current dysthymics had depressive personality disorder. Forty-eight percent of the depressive personality disorder subjects did not have current dysthymia, and 40% did not have lifetime dysthymia. Importantly, the overlap between depressive personality disorder and early-onset dysthymia was similar to that between depressive personality disorder and dysthymia overall. Approximately 61% of the individuals with depressive personality disorder did not have early-onset dysthymia.

Regarding quality of life, those with depressive personality disorder had significantly lower scores on the mental health (psychological stress and well-being) and health perception (feelings of current health) scales of the Medical Outcome Study Short-Form General Health Survey.

Moreover, subjects with depressive personality disorder scored significantly worse on five of the nine scales of the Social Adjustment Scale Self-Report inventory of social function. These scores revealed substantially worse functioning in a broad range of social behaviors in those with depressive personality disorder compared with those without depressive personality disorder.

Based on their findings, Hirschfeld and Holzer III (1994) concluded that, although the relationship of depressive personality disorder with key mood disorders was similar, depressive personality disorder was not synonymous with any of the mood disorders examined, particularly dysthymia. They asserted that: (a) the diagnostic criteria that were used to define depressive personality referred to personality styles, not to affective symptomatology; (b) the diagnostic criteria were consistent with clinical descriptions of a number of theorists; (c) the Diagnostic Interview for Depressive Personality operationally defined the disorder; (d) the reliability of the Diagnostic Interview for Depressive Personality was very good; (e) in completed studies, the prevalence rate ranged from 19 percent to 59 percent; and (f) depressive personality disorder overlapped with mood disorders but was not congruent with any of them.

Conclusions

The question of whether or not depressive personality disorder is a distinct disorder separate from mood disorders or other personality disorders has historically been debated by researchers and theorists and remains a topic of disagreement. A review of the empirical literature has both clarified some of the perplexities of the diagnosis and provided direction for further study.

In order to differentiate depressive personality disorders from mood disorders, it is necessary to review the general distinctions between the mood disorders and personality disorders. Personality disorders have an early onset; have cognitive, affective, and interpersonal features; are characteristic of a person's mode of functioning; lead to significant distress or impairment in social, occupational, or other important areas of functioning; and are persistent. In contrast, mood disorders can begin at any time and are usually episodic, and their composite symptoms tend to reflect disturbances of mood, drive, and soma (Hirschfeld & Holzer III, 1994).

Empirical researchers have attempted to elucidate the distinctiveness between depressive personality and mood disorders, and have succeeded in clarifying some kinds of distinctions between the two disorders. Akiskal et al. (1980), Akiskal et al. (1981), and Akiskal (1983) proposed that early-onset dysthymia may be a heterogeneous category

of characterological depressions consisting of subaffective dysthymia and character spectrum disorders. They suggested that individuals in the subaffective dysthymia group may display personality traits consistent with depressive personality. Their proposal paved the way for many succeeding researchers to clarify the distinctions between subcategories of dysthymia and between dysthymia and major depression.

Even though it may appear that dysthymia and depressive personality disorder overlap as suggested in several studies on depressive personality, the overlap was consistently modest. In the Klein (1990) clinical sample, only 34% of the patients who met the criteria for depressive personality met the criteria for primary early-onset dysthymia. Moreover, the Klein and Miller (1993) study involving a nonclinical sample revealed that only 19% of individuals meeting the criteria for depressive personality had lifetime diagnoses of dysthymia. In the Hirschfeld and Holzer III (1994) study, only 51% of individuals with depressive personality also met the criteria for dysthymia.

In addition to the modest overlap between depressive personality and mood disorders, defining traits between the disorders appear to differ in quality. In developing the Diagnostic Interview for Depressive Personality, Gunderson et al. (1994) indicated most of the traits on the Interview had low correlations with indexes of depressed mood or major

depressive disorder. In addition, many depressive disorder traits were cognitive, intrapsychic, and interpersonal, in contrast to traits used to define dysthymic disorder in DSM-III-R (1987) and DSM-IV (1994), which are mainly somatic. As well as making a distinction between depressive personality and mood disorders, researchers have made some headway in discriminating depressive personality from other personality disorders. In their comparisons of patients with and without depressive personality disorder, Klein (1990) and Klein and Miller (1993) discovered that although a greater proportion of individuals with depressive personality received a diagnosis of schizotypal personality disorder, the groups did not differ on rates of borderline personality disorder, panic disorder, alcohol or drug abuse, or conduct disorder.

Even though there were few personality distinctions between individuals with and without depressive personality in the Klein (1990) and Hirschfeld and Holzer III (1994) studies, both revealed significantly poorer social functioning in those with than without depressive personality. In the Klein (1990) study, patients with a depressive personality exhibited higher levels of stress reactivity, self-criticism, depressive attributions, and dysfunctional attitudes than those without depressive personality. In the Hirschfeld and Holzer III (1994) study, those individuals with depressive personality disorder

exhibited substantially worse functioning in a broad range of social behaviors than those without depressive personality disorder.

From a review of the literature, it appears that depressive personality disorder is distinct from Axis I mood disorders and from some other personality disorders. Moreover, depressive personality appears to be manifested in cognition, affectivity, and interpersonal functioning. It emphasizes personality aspects, including self-concepts, interpersonal behaviors, expectations, and attitudes. It is a stable pattern of long duration with early onset.

Subsequent investigations should focus on further discrimination between depressive personality disorder and other personality disorders. Additionally, the small overlap between early-onset dysthymia and depressive personality should be studied further to increase understanding of the relationship between the two disorders. Moreover, treatment outcome studies may be important for enabling clearer diagnosis and for developing treatment strategies.

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APPENDIX

Diagnostic Interview for Depressive Personality (DID)

Unpublished instrument

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John G. Gunderson, M. D.

McLean Hospital, Belmont, MA.

DIAGNOSTIC INTERVIEW FOR DEPRESSIVE PERSONALITY

(DID)

The Psychosocial Research Program
McLean Hospital, Belmont, MA

1992

Patient's name: _____ Age: _____ Sex: _____

Clinical status: _____

Date of interview: _____ Rater: _____

INSTRUCTIONS TO RATER

This interview collects information about different aspects of functioning -- subjective states, cognitions, and interpersonal relations (e.g., chronic unhappiness, tenseness, negativism, and unassertiveness) -- which are believed to reflect traits of the depressive personality . Be sure to read the directions to each patient (next page).

Interviewers rate each subject for the presence or absence of twenty-six depressive traits (i.e., enduring characteristics). The scoring is based on information obtained from the questions or from observations of behavior made during the interview.

If desired or necessary, questions can be followed by one or more probes, such as: "Can you give me an example?"; "About how much of the time are you like that?"; "Do you think you are more like that than most other people are?"; "Is this the way you usually are?"

SCORING OF TRAITS/CHARACTERISTICS

2=trait present; mark (+) or (Y)
1=trait possibly [moderately, sometimes] present; mark (+/-) or (?)
0=trait not present; mark (-) or (N)

Statement scores are added to form SECTION SCORES. These scores will be converted into a TOTAL SCORE from which diagnostic judgements can be derived.

DIRECTIONS TO PATIENT: These questions attempt to get a portrait of your usual self. Please try to answer according to how you have generally been over the years since childhood or adolescence. Do not base you answers on what you are like only during severe depressive episodes,

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unless this is your usual state.

I. NEGATIVISTIC

1. Are you often preoccupied with unpleasant thoughts? In other words, do you brood? _____
2. Do you often feel gloomy? _____

C1 **The Person is Gloomy** ---------- 2 1 0

3. Are you the sort of person who usually expects the "worst"? _____
4. Do you believe that "If something could go wrong, it will?" _____
5. Do you find it difficult to view the future with enthusiasm? _____

C2 **The Person is Pessimistic** - expects bad things to happen ------- 2 1 0

6. Do you have particularly strong negative reactions when bad things happen (e.g., sadness, worry, anger)? _____ Does this occur even after minor events? _____
7. Would others describe you as someone who tends to overreact when bad things happen? _____

C3 **The Person Has Negative Reactivity** ---------- 2 1 0

8. Do you often feel that life has been unfair? _____
9. In retrospect, do you often feel you've been taken advantage of? _____
10. Would others generally describe you as someone with a "chip on your shoulder"? _____

C4 **The Person is Bitter** ---------- 2 1 0

[rate 2 only when bitterness is fairly pervasive, i.e., not related only to specific situations of being victimized]

11. Do you often feel guilty about things you have or haven't done? _____
12. Do you tend to feel remorseful about your past behaviors? _____

C5 **The Person is Remorseful** - feels guilty ---------- 2 1 0

13. Would you say that you have low self-esteem? _____
14. Do you tend to consider yourself inadequate? _____

C6 **The Person Has Low Self-esteem** ---------- 2 1 0

3

15. Would you describe yourself as a worrier? _____
16. Do you often find occasions or problems in your daily life, or possibly even in the news, which cause you to worry? _____
17. Do you think you worry too much? ____
C7 **The Person is Given to Worry** ---------- 2 1 0

18. Do you usually feel weighted down by responsibilities, duties? _____
19. Do you feel burdened? _____
C8 **The Person Feels Burdened** ---------- 2 1 0

20. Do you often think that others could or should do better (even though you may not let them know this)? _____
21. Are you especially aware of and bothered by the limitations and failures of others (even though you may keep these thoughts to yourself)? _____
C9 **The Person Often Feels Critical of Others** ---------- 2 1 0

22. Are you often critical of yourself? _____
23. Do you put yourself down a lot? _____
24. Would others say that you are hard on yourself? ____
25. Do you often feel that you could or should do better? ____
26. Are you very aware of or very bothered by your limitations and failures? _____
C10 **The Person is Self-critical** ---------- 2 1 0

27. Do you generally feel physically weak? ____
28. Do you lack energy? ____
29. Do you often feel tired? _____
C11 **The Person is Asthenic** ---------- 2 1 0

SECTION TOTAL _____

II. INTROVERTED/TENSE

30. Are you a reserved person? _____
31. Do you have such a tendency to keep your thoughts to yourself that it causes you trouble? _____
32. Are you a private person who doesn't reveal much about your own activities to others? _____
33. Do you think you should speak up, express yourself more? _____ Do others? _____
C12 **The Person is Introverted** - inhibited; not expressive -------- 2 1 0

C13 **The Person Appears Quiet** ---------- 2 1 0

C14 **The Person is Serious** ---------- 2 1 0
[judge the person's demeanor]

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34. Are you a person who tends not to develop new interests and enjoy new situations? _____
35. Do you feel so strongly attached to what you know [i.e., situations, things, and people] that you are reluctant to "sample" new things or situations? _____
C15 **The Person is Constricted** ---------- 2 1 0

C16 **The Person Appears Tense** ---------- 2 1 0
[The person appears/acts apprehensive, physically tight]

36. Is it difficult for you to have fun? _____
37. Do you enjoy things less or have less fun than most people? ____
38. Do you laugh less than most people? _____
C17 **The Person Has a Limited Capacity for Fun** ---------- 2 1 0

C18 **The Person is Unsociable** - avoids and/or takes little pleasure in social activities 2 1 0

SECTION TOTAL _____

PASSIVE/UNASSERTIVE

39. Is it difficult for you to voice your opinions? _____
40. Are you often in situations you don't like because of lack of assertiveness? _____
41. Do you avoid stating your views when you expect others to disagree? _____
C19 **The Person is Unassertive** ---------- 2 1 0

42. Do you tend to let others take the lead or initiative? ____
43. Would others tend to describe you as a generally passive person? _____
44. Would you describe yourself as more of a follower than a leader? _____
C20 **The Person is Passive** - prefers to have others take the initiative ---------- 2 1 0

45. Do you tend to seek other people's opinions and rely on others to make your decisions? _____
46. Do you tend to need a lot of emotional support and reassurance (even though you might not ask for it)? _____
47. Do you need to be told that you're loved by others more than most people do (even though you might not tell them this)? ___
48. Do other people think that you are too needy or too draining? _____
C21 **The Person is Overly Dependent** ---------- 2 1 0

5

49. Would other people describe you as someone who criticizes and blames others? _____
50. Do you find it difficult to criticize or blame others? _____
Is it easier for you to blame yourself? _____
51. Do you tend to feel guilty about having critical or angry thoughts about other people? _____
C22 **The Person Finds It Difficult to Be Critical or Angry With Others** ---------- 2 1 0

52. Would you describe yourself as overly sensitive to rejection? _____ Would others? _____
53. Do you often misinterpret the behavior of others so that you end up feeling rejected when that wasn't their intent? ___
C23 **The Person is Hypersensitive to Rejection** ---------- 2 1 0

54. Are you taken care of by others more than most people are? _____ Do you like to be taken care of by others? ___
55. Do you feel unable to support yourself financially? Are you afraid to be employed? _____
56. Are others sometimes needed to get you to feed, bathe, or dress yourself? _____
C24 **The Person is Oral** - undue need to be taken care of ---------- 2 1 0

57. Do you usually need nine or more hours of sleep during the course of the day? ____
58. Do you tend to feel physically slowed down, and unable to get going in the morning? ____
59. Is it notably easier for you to get going later in the day? ____
C25 **The Person Has Psychomotor Inertia** ----------2 1 0
(worse in the mofning)

60. Are you less interested in sexual relationships than most people you know? ____
61. Do you spend less time thinking about or engaged in sexual activity than most people? ____
C26 **The Person Has Low Sexual Drive** ---------- 2 1 0

SECTION TOTAL _____

SELF-DENYING

49. Do you feel that your seeking help or support would be burdening to others? _____
50. Do you feel that you should be strong enough so as not to have to ask for support or reassurance from others? _____
51. Is it hard for you to be dependent on others? _____
C22 Counterdependent ---------- 2 1 0
[person finds it difficult to express dependency needs]

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52. Would you describe yourself as a moralistic person? _____
More so than most people? _____
53. Are you often or especially concerned with questions of right or wrong? _____
54. Do you think that sometimes you are too strict or rigid about what's right and wrong? _____
C23 **The Person is Moralistic** ---------- 2 1 0

60. Are there activities that you would enjoy but don't allow yourself to partake in? _____
61. Could you enjoy life more if you were more self-indulgent? __
C25 **The Person is Self-denying** ---------- 2 1 0

62. Do you think you settle for achieving less in life then you're capable of? _____
63. Would you or others describe yourself as an under-achiever? _____ as unambitious? _____
C26 **The Person is an Underachiever** ---------- 2 1 0

SECTION TOTAL _____

OVERALL SCORING: (Total of component sections)

NEGATIVISTIC (Range 0-18)	_____
INTROVERTED/TENSE (Range 0-12)	_____
PASSIVE/UNASSERTIVE (Range 0-12)	_____
SELF-DENYING (Range 0-10)	_____
INTERVIEW TOTAL	_____

[Score of ≥ 37 is considered to be likely Depressive Personality Disorder]

CLINICAL DIAGNOSTIC IMPRESSION: (Circle Best Estimate: 1 = absent, 2 = unlikely or minimal, 3 = possible, 4 = likely, 5 = definitely present)

Depressive Personality	1 2 3 4 5
Other Personality Types	
1. Obsessive-compulsive	1 2 3 4 5
2. Masochistic	1 2 3 4 5
3. Other	1 2 3 4 5

Depression (circle best estimate)
5. severe
4. moderate
3. mild
2. minimal
1. absent

VITA

NAME:

Beverley A. Sale

EDUCATION:

Rosemead School of Psychology Clinical Psychology	Psy.D.	(Cand.)
Rosemead School of Psychology Clinical Psychology	M.A.	1993
California State University, Fullerton Experimental Psychology	M.A.	1991
California State University, Fullerton Psychology	B.A.	1989

INTERNSHIP:

Minirth-Meier New Life Clinics, West Anaheim, California	1994 -	1995

PRACTICA:

Minirth-Meier Clinics, West Santa Ana, California Inpatient Program		1994
Harbor-UCLA Medical Center Torrance, California Outpatient Program	1993 -	1994
Biola Counseling Center La Mirada, California Outpatient Program	1992 -	1993
Lakeside Middle School Irvine, California School Practicum		1992

EMPLOYMENT:

John D. Carter, Ph.D. Marriage, Family, Child Counselor Intern Santa Ana, Ca.	1995	- present
Biola Counseling Center Staff Therapist La Mirada, Ca.	1993 -	1994